STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from August 31, 2011 through September 2, 2011, utilizing the fundamental survey process. A random sample of three clients was selected from a population of three females and two males with various levels of intellectual and developmental disabilities. The findings of the survey were based on observations at the group home, two day programs, interviews with clients, family member and staff and the review of clinical and administrative records, including incident reports. [Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report].	W 000	Received 10/11/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services meet the needs of each client, for one of the three clients in the sample. (Client#2) The finding includes: On August 31, 2011, beginning at 12:33 p.m., observations conducted at the day program revealed Client #2 was observed sitting in a custom molded wheelchair with a lap tray attached to it. Further observations revealed that	W 120	The QIDP reported to client #2's day program on 9-06-11 to enservice the day service staff on the proper wheelchair positioning including feet and legs. Refer to attachment #1. In the future, the QIDP will ensure that the day program properly position client #2 on her wheelchair. To ensure that the recommendations are followed upon, QIPD will make frequent unannounced visits at the day program.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Annette Glanville | TITLE: Program Director | (X6) DATE: 9-23-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 120	Continued From page 1 the wheelchair was observed with leg and footrests. At 12:38 p.m., Client #2's feet were observed placed directly behind the leg/footrests. At 12:51 p.m., staff asked Client #2 was she okay. The client replied, by shaking her head yes. At that time, the staff was not observed to reposition the client's legs properly onto the wheelchair leg and footrest. At 1:12 p.m., Client #2 was observed trying to position her legs onto the leg and footrests but was unsuccessful. The surveyor informed the staff that Client #2's feet were not placed properly onto the footrests. At approximately 1:16 p.m., the staff placed the client's feet back onto the wheelchair leg and footrest. At approximately 1:18 p.m., interview with the day program staff on the same day revealed that she was unaware that Client #2's feet were positioned behind the wheelchair leg and footrests. Staff indicated that was a poor oversight on her part. At the time of the survey, the facility failed to ensure that Client #2's legs and feet were properly positioned onto her wheelchair as prescribed.	W 120	The QIDP reported to client #2's day program on 9-06-11 to enservice the day service staff on the proper wheelchair positioning including feet and legs. Refer to attachment #1. In the future, the QIDP will ensure that the day program properly position client #2 on her wheelchair. To ensure that the recommendations are followed upon, QIPD will make frequent unannounced visits at the day program. The QIDP reported to client #2's day program on 9-06-11 to enservice the day service staff on the proper wheelchair positioning including feet and legs. Refer to attachment #1. In the future, the QIDP will ensure that the day program properly position client #2 on her wheelchair. To ensure that the recommendations are followed upon, QIPD will make frequent unannounced visits at the day program.	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the qualified intellectual disabilities professional (QIDP) failed to coordinate, monitor,	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 2 integrate each client's active treatment, for four of five residents residing in the facility. (Clients #1, #2, #3 and #4) The findings include: 1. Cross refer to W120. The facility's QIDP failed to ensure that outside services met the needs of each client, for one of the three clients in the sample. (Client#2) 2. Cross refer to W189. The facility's QIDP failed to ensure that each employee was provided with effective training that enabled the employee to perform his or her duties effectively, efficiently, and competently for Client #2. 3. Cross refer to W249 and W371. The facility's QIDP failed to implement an effective system to ensure that each client participated in a self-medication training program, for two of three clients included in the sample. (Clients #1 and #2) 4. Cross refer to W436. The facility's QIDP failed coordinate and monitor services to ensure Client #3's right wrist hand splint was furnished and maintained in condition and failed to ensure Client #4's wheelchair footrest were furnished.	W 159	Refer to W 120 P 1&2 Attachment # 1 Refer to W 189 P 3&4 Attachment #2 Refer to W 249 P.5, 6, &7 Attachment #3 Refer to W 371 P 7, 8, 9, 10, 11 Attachment #4 Refer to attachment #5a Attachment # 5b Attachment # 5c Attachment # 6a Attachment #6b	9-06-11 9-15-11 9-22-11 9-03-11 9-07-11 9-15-11 9-16-11 9-02-11 9-06-11
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 3	W 189		

review, the facility failed to ensure that each employee was provided initial and continued training that enabled the employee to perform his or her duties effectively, efficiently, and competently for one of three clients in the sample. (Client #2)

The finding includes:

Record review on September 2, 2011, at approximately 10:10 a.m., failed to provide evidence of inservice training on the use of wheelchair safety.

On August 31, 2011, at 9:43 a.m., Client #2 was observed sitting in a custom molded wheelchair watching television in the living room. A few minutes later, Client #2 was transported to the company van for departure to the day program. Staff #1 was observed to place the client's wheelchair onto the wheelchair lift, locked the wheelchair, and remained on the side of the lift as the wheelchair was raised up to the back of the van. Staff #2 was observed standing at the back of the van for support. The wheelchair strap was observed attached to the wheelchair lift which was not used by Staff #1.

Interview with Staff #2 on the same day at 9:50 a.m. revealed that the strap attached to the wheelchair should have been used to further secure Client #2 while being loaded onto the wheelchair lift. Interview with Staff #1, who admittedly did not secure Client #2 using the strap attached to the wheelchair, revealed that the strap was a little short. Continued observations later that afternoon at 3:50 p.m., Staff #3 was observed to show Staff #1 how to

All staff were trained by Oneness Mobility on 9-15-11
The training included Whelechair tie down,
Wheelchair securement system, Safety,
Securement system in and out of vehicle,
Pretrip assessment, Wheelchair lift general
precautions Wheelchair lift operations (power manual)
The training was on client #2's wheelchair safety
as well as the rest of the client on wheelchairs
in the facility.
Refer to attachment #2.
In the future, the facility management will
ensure that staff are trained on the use of
wheelchair safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 4 secure Client #2's wheelchair using the wheelchair strap attached to the wheelchair lift. Interview with Staff #1 and the qualified intellectual disabilities professional (QIDP) on September 2, 2011, at 10:07 a.m., revealed that she had received training on securing client's wheelchair on the van. Interview with the residential director (RD) and the registered nurse (RN) on the same day at approximately 3:50 p.m., revealed that all staff had received training on wheelchair security. Review of the in service training records on September 2, 2011, at 10:20 a.m., revealed there was no documented evidence that staff had received training on wheelchair security. It should be noted that the surveyor had requested evidence of the wheelchair security training for all staff on September 2, 2011, at approximately 10:10 a.m.	W 189	All staff were trained by Oneness Mobility on 9-15-11 The training included Wheelchair tie down, Wheelchair securement system, Safety, Securement system in and out of vehicle, Pretrip assessment, Wheelchair lift general precautions Wheelchair lift operations (power manual) The training was on client #2's wheelchair safety as well as the rest of the client on wheelchairs in the facility. Refer to attachment #2. In the future, the facility management will ensure that staff are trained on the use of wheelchair safety	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each client received continuous active treatment, for two of	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 5	W 249		

the three clients in the sample. (Clients #1 and #2)

The findings include:

1. During evening observation on August 31, 2011, at 4:50 p.m., Client #1 was observed participating in table top activities. At 4:55 p.m., the client threw the blocks across the table. The staff put the blocks back in front of the client and she gently tossed them across the table. The staff asked the client if she was finished playing and the client turned her head in the opposite direction of the staff. Interview with the staff on August 31, 2011, at 5:20 p.m., revealed that the client was non-verbal and used gestures to express her needs.

Review of Client #1's individual program plan (IPP) dated November 10, 2010, on September 1, 2011, at 10:06 a.m., revealed a program objective which stated," [the client] will use manual signs (yes, no, thank you, sorry, what and please) with physical assistance from staff on 60% of recorded trials per month for three consecutive months."

On September 2, 2011, at 10:00 a.m., interview with the qualified intellectual disabilities professional (QIDP) indicated that the Client #1 does not use sign language; however, she uses gestures to express her needs. Interview with the direct support staff on September 2, 2011, at 10:40 a.m., who had been on duty the evening of August 31, 2011, revealed that the client used gestures to express her wants and needs. She further indicated that if she does not want to participate in an activity, she would throw items

Client #1 was reassessed by the QIDP on 9-21-11
Client #1 does not communicate with sign language.
The goal has been revised and the criteria was changed to physical assistance.
Staff has been trained to physically assist client #1 in the implementation of the table top activities.
Refer to attachment #3
The Speech and Language Pathologist will assess client #1 on 9-30-11
In the future, the QIDP will ensure that client #1's goal and objective coincide with her cognitive and adaptive abilities.

Client #1 was reassessed by the QIDP on 9-21-11
Client #1 does not communicate with sign language.
The goal has been revised and the criteria was changed to physical assistance.
Staff has been trained to physically assist client #1 in the implementation of the table top activities.
Refer to attachment #3
The Speech and Language Pathologist will assess client #1 on 9-30-11
In the future, the QIDP will ensure that client #1's goal and objective coincide with her cognitive and adaptive abilities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 6 across the table or the room. Reveiw of the QIDP quarterly notes dated from November 2010 through August 6, 2011, on Septebmer 2, 2011, at 10:55 a.m., revealed that Client #1 required 40% physical assistance to complete the signs. The notes further revealed that the client should continue to receive training on the manual sign language IPP. The QIDP confirmed that the client does not use manual signs and she would speak to the staff that worked on August 31, 2011, and documented on Client #1's sign language IPP. 2. Cross Ref W371. The facility failed to implement an effective system to ensure that each client participated in a self-medication training program, for two of three clients included in the sample. (Clients #1 and #2)	W 249	Client #1 was reassessed by the QIDP on 9-21-11 Client #1 does not communicate with sign language. The goal has been revised and the criteria was changed to physical assistance. Staff has been trained to physically assist client #1 in the implementation of the table top activities. Refer to attachment #3 The Speech and Language Pathologist will assess client #1 on 9-30-11 The Speech and Language Pathologist will assess client #1 on 9-30-11 In the future, the QIDP will ensure that client #1's goal and objective coincide with her cognitive and adaptive abilities.	
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, interviews and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program, for two of three clients included in the sample. (Clients #1 and #2) The findings include:	W 371	Refer to W 371 P 7, 8,9, 10,11 Attachment #4	9-03-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 371	Continued From page 7	W 371		

1. Observation of the medication administration on August 31, 2011, at 4:35 p.m., revealed the licensed practical nurse (LPN) prepared Client #1's medications. He punched a pill into a medicine cup, crushed the pill, placed into a cup of applesauce and spoon fed the client her medication. The LPN then held a cup up to the client's mouth as she client drank water. When finished, the LPN placed the medicine cup into the trash can. At 6:50 p.m., the LPN was observed preparing Client #1's medications. He punched the pills into a medicine cup, crushed the pills, placed them a cup of applesauce and spoon fed the client her medications. At no time did the LPN encourage the client to participate in the self-medication administration.

Interview with LPN on the same day, after the medication administration, revealed that the client does not participate in a self medication program.

Review of Client #1's self medication assessment dated May 26, 2011, on September 1, 2011, at 9:45 a.m., revealed that the client is capable of self administering medication with assistance and under close supervision. At that time, a training program was recommended and the interdisciplinary team accepted the training program.

Review of Client #1's Individual Program Plan (IPP) dated November 10, 2010, on September 1, 2011, at 10:06 a.m., revealed a program goal which stated, "increase her self medication participation skills". Further review indicated Client #1's self-medication program was outlined as follows:

Client #2 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #2's self medication program is fully implemented per protocol. 9-03-11
Refer to attachment #4.
In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program.

Client #1 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #1's self medication program is fully implemented per protocol. 9-03-11
Refer to attachment #4.
In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 371	Continued From page 8 - With hand over hand assistance from the nurse, [the client] will accept the dispensed mediation from the nurse; - With hand over hand assistance from the nurse, [the client] will put the medication in her mouth; and - With hand over hand assistance from the nurse, [the client] will swallow her medications with a cup of water. Review of Client's #1 program documentation record on September 1, 2011, at approximately 12:30 p.m., revealed that the LPN documented that the client required hand over hand assistance. Interview with the facility's registered nurse on September 1, 2011, at approximately 1:00 p.m., revealed that the LPN should encourage Client #1 to participate in the self medication program. 2. Observation of the medication administration on August 31, 2011, at 6:26 p.m., revealed the licensed practical nurse (LPN) preparing Client #2's medications. He punched the pills into a medicine cup, crushed the pills, placed into a cup of applesauce and spoon fed the client her medication. The LPN then held the cup up to the client's mouth as she client drank the water. When finished, the LPN placed the medicine cup into the trash can. At no time did the LPN encourage the client to participate in the self-medication administration. Interview with LPN on the same day, after the medication administration, revealed that the client	W 371	Client #1 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #1's self medication program is fully implemented per protocol. 9-03-11 Refer to attachment #4. In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program. Client #2 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #2's self medication program is fully implemented per protocol. 9-03-11 Refer to attachment #4. In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 371	Continued From page 9 does not participate in a self medication program. Review of Client #2's self medication assessment dated May 26, 2011, on September 1, 2011, at 11:00 a.m., revealed that the client is capable of self administering medication with assistance and under close supervision. At that time, a training program was recommended and the interdisciplinary team accepted the training program. Review of Client #2's Individual Program Plan (IPP) dated October 25, 2011, on September 1, 2011, at 12:06 p.m., revealed a program goal which stated, "increase her self medication participation skills". Further review indicated Client #1's self-medication program was outlined as follows: - With hand over hand assistance from the nurse, [the client] will accept the dispensed mediation from the nurse; - With hand over hand assistance from the nurse, [the client] will put the medication in her mouth; and - With hand over hand assistance from the nurse, [the client] will swallow her medications with a cup of water. Review of Client's #2 program documentation record on September 1, 2011, at approximately 2:30 p.m., revealed that the LPN documented that the client required hand over hand assistance. Interview with the facility's registered nurse on September 1, 2011, at approximately 3:00 p.m., revealed that he LPN should	W 371	Client #2 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #2's self medication program is fully implemented per protocol. Refer to attachment #4. In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program. Client #2 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #2's self medication program is fully implemented per protocol. Refer to attachment #4. In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program.	9-03-11 9-03-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 371	Continued From page 10 encourage Client #2 to participate in the self medication program.	W 371		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to furnish and maintain in good condition hand splint, neck brace, and wheelchair, as prescribed, for two of the four clients residing in the facility. (Clients #3 and #4) The findings include: 1. The facility failed to furnish and maintain in condition Client #3's right wrist handsplint. On August 31, 2011, at 9:55 a.m., Client #3 was observed sitting in a custom molded wheelchair watching television in the living room area. The client's right hand appeared to be contracted. A few seconds later, interview with the licensed practical nurse (LPN) verified that the Client #3's right hand was contracted. On September 2, 2011, at 9:58 a.m., review of Client #3's individual support plan (ISP) dated December 18, 2010, revealed an occupational therapist (OT) quarterly review May 2011. The OT review revealed that Client #3 would continue to benefit from the hand splint to maintain his current range of motion	W 436	Client #3 was wearing his hand splint at his residence prior to his hospitalization from 8-8-11 to 8-25-11 when he was discharged from the nursing home, and returned to his residence at 617 Dahlia street NW. According to the staff, Mr. Jones wore his hand splint after the hospitalization. The staff did not report to the house management team that Mr. Jones' hand splint was not in place. Once the home management team was aware of the missing hand splint, the DON contacted The PCP to request the pos and 719-A was signed by the PCP on 9-07-11. Refer to attachment # 5 a Hanger Prosthetics & Othotics was contacted for Mr. Jones' hand splint fitting appointment, which was scheduled on 9-15-11 Refer to attachment 5b The Occupational Therapist reported to the home, and completed Mr. Jones' IPP and data collection sheet. 9-16-11 Refer to attachment 5c. Staff were trained on the adaptive equipment by the QIDP on 9-22-11 Refer to attachment # 5d In the future, the facility management will ensure that the individuals' adaptive equipment are furnished, and in good repair. All staff were disciplined for failure to report the missing hand split to the facility management.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 11	W 436		

(ROM), prevent contractures, and encourage an open hand posture.

Interview with the same LPN on September 2, 2011, at 10:15 a.m., revealed the client was had a right wrist hand splint to address his contractures of the right hand. Further interview revealed the hand splint should be worn for three hours and off for one hour. When asked to see the hand splint, the LPN was unable to produce any evidence of it. A telephone interview conducted with the OT on September 2, 2011, at 3:20 p.m., confirmed the LPN's aforementioned interview.

At the time of the survey, there was no evidence that Client #3's furnished and maintained in good repair.

2. On August 31, 2011, at 7:45 a.m., Client #4 was observed laying on the sofa with a manual wheelchair placed in front of him. At 9:15 a.m., staff was observed propelling the client to the bathroom. During the transition, Client #4's feet were dragging on the floor, underneath the manual wheelchair. Seconds later, the staff was interviewed to ascertain information regarding whether or not footrests were required on her wheelchair. The staff replied, "I am not aware that the client has or uses footrest for his wheelchair." Interview with the qualified intellectual disabilities professional (QIDP), on the same date, at approximately 11:00 a.m., revealed that since her employment (May 2011) she had not seen any footrest on Client #4's wheelchair.

Review of Client #4's record on September 2, 2011, at approximately 10:00 a.m., revealed a

Refer to W 436 P 11 9-07-11
Attachment #5a
Attachment # 5b 9-15-11
Attachment #5c 9-16-1
Attachment #5d

Client #4's swing away footrests were found on 9-02-11
There were inside the closet.
Refer to attachment # 6a
Another 719-A was signed by the PCP for
the order of the new pair of footrests on 9-06-11
Refer to attachment # 6b
Staff were trained on the adaptive equipment by the
by the QIDP on 9-22-11
Refer to attachment # 5d
in the future, the facility management will
ensure that the individuals' adaptive equipment
are available and in good repair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 12 third physical therapy (PT) quarterly progress review dated August 12, 2011, that recommended that Client #4's wheelchair obtain swing away, removable footrest with fold up footplates for his wheelchair. On September 2, 2011, at 11:30 a.m., the RN provided a durable medical equipment (DME) order dated December 1, 2010. The DME order revealed that a standard wheelchair with footrest was delivered to Client #4's home on December 3, 2011. Further interview with the RN and PD, revealed no evidence of the whereabouts of Client #4's footrest. The QIDP informed the survey, that she called all the staff, inquiring about Client #4's footrest, to no avail. At the time of the visit, the facility failed to provide evidence of Client #4's footrest.	W 436	Client #4's swing away footrests were found on 9-02-11 There were inside the closet. Refer to attachment # 6a Another 719-A was signed by the PCP for the order of the new pair of footrests on 9-06-11 Refer to attachment # 6b Staff were trained on the adaptive equipment by the QIDP on 9-22-11 Refer to attachment # 5d in the future, the facility management will ensure that the individuals' adaptive equipment are available and in good repair.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS A licensure survey was conducted from August 31, 2011 through September 2, 2011. A random sample of three residents was selected from a population of three females and two males with various intellectual and developmental disabilities. The findings of the survey were based on observations and an interview with one family member and residents, staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports. [Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report].	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to maintain the interior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for one of five residents residing in the home. (Resident #5) The finding includes: Observation and interview conducted with the facility qualified intellectual disabilities professional (QIDP) on September 2, 2011, beginning at 2:20 p.m., revealed the following:	I 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 090	Continued From page 1 1. Observation of Client #5's bedroom revealed that her bed was observed with gray duck tape on the left side at the foot board. The black trimming/molding on top of the foot board was observed to be detached from the foundation. 2. There was a block of wood underneath Client #5's bed located near the head rest that was attached to the wall. The wood was placed there to keep the client's head board from damaging the wall. However, the bed remained approximately 5 inches from the wall which caused the closet door not open fully. The QIDP confirmed the above-cited deficiencies at the conclusion of the environmental walk-through.	I 090	The grey duck tape on the left side of the foot board removed on 9-06-11 In the future, the facility management will ensure that the interior of the bedroom of client's #5 is safe clean and attractive. The block of wood underneath Client #5 bed located near the head rest was removed on 9-06-11 In the future, the facility management will ensure that the interior of the bedroom of client's #5 is safe clean and attractive.	
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure adequate administrative support had been provided to effectively meet the needs, for three of three residents in the sample. (Resident #2, #3 and #4) The findings include: 1. Cross refer to federal deficiency citation W189. The GHPID's QIDP failed to ensure that each employee was provided with effective	I 180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 180	Continued From page 2	I 180		

training that enabled the employee to perform his or her duties effectively, efficiently, and competently for Resident #2.

2. The GHPID's QIDP failed coordinate and monitor services to ensure Resident #3's right wrist hand splint was furnished and maintained in condition, as evidenced below.

On August 31, 2011, at 9:55 a.m., Resident #3 was observed sitting in a custom molded wheelchair watching television in the living room area. The resident's right hand appeared to be contracted. A few seconds later, interview with the licensed practical nurse (LPN) verified that the Resident #3's right hand was contracted. On September 2, 2011, at 9:58 a.m., review of Resident #3's individual support plan (ISP) dated December 18, 2010, revealed an occupational therapist (OT) quarterly review dated May 2011. The OT review revealed that Resident #3 would continue to benefit from the hand splint to maintain his current range of motion (ROM), prevent contractures, and encourage an open hand posture.

Interview with the same LPN on September 2, 2011, at 10:15 a.m., revealed the resident was had a right wrist hand splint to address his contractures of the right hand. Further interview revealed the hand splint should be on for three hours and off for one hour. When asked to see the hand splint, the LPN was unable to produce any evidence of it. A telephone interview conducted with the OT on September 2, 2011, at 3:20 p.m., confirmed the LPN's aforementioned interview.

At the time of the survey, there was no evidence that Resident #3's furnished and maintained in

Refer to W 120 P 1&2 of 13 9-06-11
Attachment #1

Client #3 was wearing his hand splint at his residence prior to his hospitalization from 8-8-11 to 8-25-11 when he was discharged from the nursing home, and returned to his residence at 617 Dahlia street NW.
According to the staff, Mr. Jones wore his hand splint after the hospitalization. The staff did not report to the house management team that Mr. Jones' hand splint was not in place.
Once the home management team was aware of the missing hand splint, the DON contacted The PCP to request the POS and 719-A was signed by the PCP on 9-07-11.
Refer to attachment # 5 a
Hanger Prosthetics & Othotics was contacted for Mr. Jones' hand splint fitting appointment, which was scheduled on 9-15-11
Refer to attachment 5b
The Occupational Therapist reported to the home, and completed Mr. Jones' IPP and data collection sheet.
Refer to attachment 5c 9-16-11
Staff were trained on the adaptive equipment by the QIDP on 9-22-11
Refer to attachment # 5d
In the future, the facility management will ensure that the individuals' adaptive equipment are furnished, and in good repair.
All staff were disciplined for failure to report the missing hand split to the facility management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 180	Continued From page 3 good repair. This is a repeat deficiency. 3. On August 31, 2011, at 7:45 a.m., Resident #4 was observed laying on the sofa with a manual wheelchair placed in front of him. At 9:15 a.m., staff was observed propelling the resident to the bathroom. During the transition, Resident #4's feet were dragging on the floor, underneath the manual wheelchair. Seconds later, the staff was interviewed to ascertain information regarding whether or not footrests were required on her wheelchair. The staff replied, "I am not aware that the resident has or uses footrest for his wheelchair." Interview with the qualified intellectual disabilities professional (QIDP), on the same date, at approximately 11:00 a.m., revealed that since her employment (May 2011) she had not seen any footrest on Resident #4's wheelchair. Review of Resident #4's record on September 2, 2011, at approximately 10:00 a.m., revealed a third physical therapy (PT) quarterly progress review dated August 12, 2011, that recommended that Resident #4's wheelchair obtain swing away, removable footrest with fold up footplates for his wheelchair. On September 2, 2011, at 11:33 a.m., the RN provided a durable medical equipment (DME) order dated December 1, 2010. The DME order revealed that a standard wheelchair with footrest was delivered to Resident #4's home on December 3, 2010. Further interview with the RN and PD, revealed no evidence of the whereabouts of Resident #4's footrest. The QIDP informed the survey, that she called all the staff, inquiring about Resident #4's footrest, to no	I 180	Client #4's swing away footrests were found on 9-02-11 There were inside the closet. Refer to attachment # 6a Another 719-A was signed by the PCP for the order of the new pair of footrests on 9-06-11 Refer to attachment # 6b Staff were trained on the adaptive equipment by the QIDP on 9-22-11 Refer to attachment # 5d In the future, the facility management will ensure that the individuals' adaptive equipment are available and in good repair. Client #4's swing away footrests were found on 9-02-11 There were inside the closet. Refer to attachment # 6a Another 719-A was signed by the PCP for the order of the new pair of footrests on 9-06-11 Refer to attachment # 6b Staff were trained on the adaptive equipment by the QIDP on 9-22-11 Refer to attachment # 5d In the future, the facility management will ensure that the individuals' adaptive equipment are available and in good repair.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 180	Continued From page 4 avail. At the time of the visit, the facility failed to provide evidence of Resident #4's footrest.	I 180		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.	I 206		
	This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that five of the nine staff (Staff #1, #2, #6 and #7), two of the eight nurses (Nurses #1 and #4) and three of the eleven consultants (primary care physician, speech pathologist and social worker) had current health certificates.		Staff #1, 2, 3, and 4's health certificates are currently on file 9-16-11 Refer to attachment # 9a & 9b 9c 9d In the future the home management will ensure the staff's health certificates are in the facility and available to monitors upon requests.	
	The finding includes: On September 2, 2011, beginning at 10:20 a.m., review of the personnel records revealed the GHPID failed to have evidence of current health certificates for five of the nine staff, two of the eight nurses, and three of the eleven consultants. The staff confirmed that the aforementioned personnel were without current health certificates in their personnel files.		The three consultants's health certificates are currently on file. 9-06-11 Refer to attachments # 10a, 10b, 10c In the future the home management will ensure the consultants 'health certificates are in the facility and available to monitors upon requests.	
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service	I 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 222	Continued From page 5 training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure a continuous, ongoing in-service training program to address the needs, for one of three residents in the sample. (Resident #2) The finding includes: Record review on September 2, 2011, at approximately 10:10 a.m., failed to provide evidence of inservice training on the use of wheelchair safety. On August 31, 2011, at 9:43 a.m., Resident #2 was observed sitting in a custom molded wheelchair watching television in the living room. A few minutes later, Resident #2 was transported to the company van for departure to the day program. Staff #1 was observed to place the resident's wheelchair onto the wheelchair lift, lock the wheelchair, and remain on the side the lift as the wheelchair was raised up to the back of the van. Staff #2 was observed standing at the back of the van for support. The wheelchair strap observed attached to the wheelchair lift was not used by Staff #1. Interview with Staff #2 on the same day at 9:50 a.m. revealed that the strap attached to the wheelchair should have been used to further secure Resident #2 while being loaded onto the wheelchair lift. Interview with Staff #1, who admittedly did not secure Resident #2 using the strap attached to the wheelchair, revealed that the strap was a little short. Continued observations later that afternoon at 3:50 p.m.,	I 222	All staff were trained by Oneness Mobility on The training included Whelechair tie down, Wheelchair securement system, Safety, Securement system in and out of vehicle, Pretrip assessment, Wheelchair lift general precautions Wheelchair lift operations (power manual) The training was on client #2's wheelchair safety as well as the rest of the client on wheelchairs in the facility. Refer to attachment #2. In the future, the facility management will ensure that staff are trained on the use of wheelchair safety	9-15-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 222	Continued From page 6 Staff #3 was observed to show Staff #1 how to secure Resident #2's wheelchair using the wheelchair strap attached to the wheelchair lift. Interview with Staff #1 on September 2, 2011, at 10:07 a.m., revealed that she had received training on securing resident's on the van. Interview with the qualified intellectual disabilities professional (QIDP) on the same day at approximately 3:50 p.m. revealed that all staff had received training on wheelchair security. Review of the in service training records on September 2, 2011, at 10:20 a.m., revealed there was no documented evidence that staff had received training on wheelchair security. It should be noted that the surveyor had requested evidence of the wheelchair security training for all staff on September 2, 2011, at approximately 10:10 a.m.	I 222	All staff were trained by Oneness Mobility on The training included Whelechair tie down, Wheelchair securement system, Safety, Securement system in and out of vehicle, Pretrip assessment, Wheelchair lift general precautions Wheelchair lift operations (power manual) The training was on client #2's wheelchair safety as well as the rest of the client on wheelchairs in the facility. Refer to attachment #2. In the future, the facility management will ensure that staff are trained on the use of wheelchair safety	9-15-11
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that all the required administrative records were available for inspection, for one of the ten consultants providing services. The finding includes:	I 271		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 271	Continued From page 7 On August 31, 2011, during the entrance conference at 10:00 a.m., the qualified intellectual disabilities professional (QIDP) agreed to make available for review the personnel records of all employees, including licensed professional health consultants. On September 2, 2011, beginning at 10:20 a.m., review of the personnel records for health care professionals revealed no evidence of a current administrative record for Nurse #4. The QIDP said she would follow-up with the agency's main office. On September 2, 2011, at approximately 12:30 p.m., the QIDP stated that she had not received a personnel record for Nurse #4. No additional information was presented before the survey ended later that afternoon.	I 271	The personnel record for nurse #4 are currently on file 9-06-11 Refer to attachment #8 In the future the facility management will ensure that all of the nurses' files are obtained from the office, and are available to monitors upon request.	
I 399	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (i) Speech and language therapy; and... This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that a copy of	I 399	The personnel record for nurse #4 are currently on file 9-06-11 Refer to attachment #8 In the future the facility management will ensure that all of the nurses' files are obtained from the office, and are available to monitors upon request.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 399	Continued From page 8 professional credentials was maintained for each individual providing professional services at the GHPID, as required by District of Columbia law, in the following disciplines or area: (i) Speech and Language Therapy. The finding is: Review of the personnel records on September 2, 2011, beginning at 10:20 a.m., revealed that a current license/professional certification was not available for the Speech Language Therapist. At approximately 12:30 p.m., the GHPID's qualified intellectual disabilities professional confirmed that the license/professional credentialing for the Speech Language Therapist was not available for review. On September 6, 2011, at approximately 11:00 a.m., a search of professional licensing records online revealed no evidence that the consulting Speech Language Therapist was licensed to practice in the District of Columbia, in accordance with: Title 3, Chapter 12 of the District of Columbia Official Code SUBCHAPTER V. LICENSING, REGISTRATION, OR CERTIFICATION OF HEALTH PROFESSIONALS § 3-1205.01.	I 399	The Speech and Language Pathologist's credentials were at the corporate office in the HR's office 9-02-11 Refer to attachment # 7 In the future the facility management will ensure that all of the clinicians' files are obtained from the office, and are available to monitors upon request. The Speech and Language Pathologist's credentials were at the corporate office in the HR's office 9-02-11 Refer to attachment # 7 In the future the facility management will ensure that all of the clinicians' files are obtained from the office, and are available to monitors upon request.	
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic	I 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 436	Continued From page 9 devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observations, interviews and the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement an effective system to ensure that each resident participated in a self-medication training program, for two of the three residents in the sample. (Residents #1 and #2) The findings include: 1. Observation of the medication administration on August 31, 2011, at 4:35 p.m., revealed the licensed practical nurse (LPN) prepared Resident #1's medications. He punched a pill into a medicine cup, crushed the pill, placed into a cup of applesauce and spoon fed the resident her medication. The LPN then held a cup up to the resident's mouth as she resident drank water When finished, the LPN placed the medicine cup into the trash can. At 6:50 p.m., the LPN was observed preparing Resident #1's medications. He punched the pills into a medicine cup, crushed the pills, placed them a cup of applesauce and spoon fed the resident her medications. At no time did the LPN encourage the resident to participate in the self-medication administration. Interview with LPN on the same day, after the medication administration, revealed that the resident does not participate in a self medication program. Review of Resident #1's self medication assessment dated May 26, 2011, on September 1, 2011, at 9:45 a.m., revealed that the resident is capable of self administering medication with assistance and under close supervision. At that	I 436	Client #1 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #1's self medication program is fully implemented per protocol. Refer to attachment #4. In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program. Client #1 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #1's self medication program is fully implemented per protocol. Refer to attachment #4. In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program.	9-03-11 9-03-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 436	Continued From page 10 time, a training program was recommended and the interdisciplinary team accepted the training program. Review of Resident #1's Individual Program Plan (IPP) dated November 10, 2010, on September 1, 2011, at 10:06 a.m., revealed a program goal which stated, "increase her self medication participation skills". Further review indicated Resident #1's self-medication program was outlined as follows: - With hand over hand assistance from the nurse, [the resident] will accept the dispensed mediation from the nurse; - With hand over hand assistance from the nurse, [the resident] will put the medication in her mouth; and - With hand over hand assistance from the nurse, [the resident] will swallow her medications with a cup of water. Review of Resident's #1 program documentation record on September 1, 2011, at approximately 12:30 p.m., revealed that the LPN documented that the resident required hand over hand assistance. Interview with the facility's registered nurse on September 1, 2011, at approximately 1:00 p.m., revealed that the LPN should encourage Resident #1 to participate in the self medication program. 2. Observation of the medication administration on August 31, 2011, at 6:26 p.m., revealed the licensed practical nurse (LPN) preparing Resident #2's medications. He punched the pills into a medicine cup, crushed the pills, placed into a cup of applesauce and spoon fed the resident her	I 436	Client #1 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #1's self medication program is fully implemented per protocol. 9-03-11 Refer to attachment #4. In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program. Client #1 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #1's self medication program is fully implemented per protocol. 9-03-11 Refer to attachment #4. In the future, the nursing team will ensure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 436	Continued From page 11 medication. The LPN then held the cup up to the resident's mouth as she resident drank the water. When finished, the LPN placed the medicine cup into the trash can. At no time did the LPN encourage the resident to participate in the self-medication administration. Interview with LPN on the same day, after the medication administration, revealed that the resident does not participate in a self medication program. Review of Resident #2's self medication assessment dated May 26, 2011, on September 1, 2011, at 11:00 a.m., revealed that the resident is capable of self administering medication with assistance and under close supervision. At that time, a training program was recommended and the interdisciplinary team accepted the training program. Review of Resident #2's Individual Program Plan (IPP) dated October 25, 2011, on September 1, 2011, at 12:06 p.m., revealed a program goal which stated, "increase her self medication participation skills". Further review indicated Resident #1's self-medication program was outlined as follows: - With hand over hand assistance from the nurse, [the resident] will accept the dispensed mediation from the nurse; - With hand over hand assistance from the nurse, [the resident] will put the medication in her mouth; and - With hand over hand assistance from the nurse, [the resident] will swallow her medications with a cup of water.	I 436	Client #2 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #2's self medication program is fully implemented per protocol. Refer to attachment #4. In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program. Client #2 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #2's self medication program is fully implemented per protocol. Refer to attachment #4. In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program. Client #2 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #2's self medication program is fully implemented per protocol. Refer to attachment #4. In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program.	9-03-11 9-03-11 9-03-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 436	Continued From page 12	I 436		

Review of Resident's #2 program documentation record on September 1, 2011, at approximately 2:30 p.m., revealed that the LPN documented that the resident required hand over hand assistance. Interview with the facility's registered nurse on September 1, 2011, at approximately 3:00 p.m., revealed that he LPN should encourage Resident #2 to participate in the self medication program.

Client #2 is encouraged to participate in self medication program during medication administration. Even if she refuses, she is offered with the opportunity to participate. All nurses have been retrained to ensure that client #2's self medication program is fully implemented per protocol. Refer to attachment #4. 9-03-11
In the future, the nursing team will ensure that all of the individuals are encouraged to fully participate in the self medication program.

I 437 3521.7(g) HABILITATION AND TRAINING I 437

The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:

(g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required);

This Statute is not met as evidenced by:
Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to provide habilitation and training, for one of the three residents included in the sample. (Resident #1)

The finding includes:

During evening observation on August 31, 2011, at 4:50 p.m., Resident #1 was observed participating in table top activities. At 4:55 p.m., the resident threw the blocks across the table. The staff put the blocks back in front of the resident and she gently tossed them across the

Client #1 was reassessed by the QIDP on 9-21-11
Client #1 does not communicate with sign language. The goal has been revised and the criteria was changed to physical assistance.
Staff has been trained to physically assist client #1 in the implementation of the table top activities. Refer to attachment #3
The Speech and Language Pathologist will assess Client #1 on 9-30-11
In the future, the QIDP will ensure that client #1's goal and objective coincide with her cognitive and adaptive abilities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 437	Continued From page 13	I 437		

table. The staff asked the resident if she was finished playing and the resident turned her head in the opposite direction of the staff. The staff put the blocks back into the bag and removed them from the table. Interview with the staff on August 31, 2011, at 5:20 p.m., revealed that the resident was non-verbal and used gestures to express her need; however the resident does not use american sign language.

Review of Resident #1's individual program plan (IPP) dated November 10, 2010, on September 1, 2011, at 10:06 a.m., revealed a program objective which stated," [the resident] will use manual signs (yes, no, thank you, sorry, what and please) with physical assistance from staff on 60% of recorded trials per month for three consecutive months."

On September 2, 2011, at 10:00 a.m., interview with the qualified intellectual disabilities professional (QIDP) indicated that the Resident #1 does not use sign language; however, she uses gestures to express her needs. Interview with the direct support staff on September 1, 2011, at 10:40 a.m., who had been on duty the evening of August 31, 2011, revealed that the resident used gestures to express her wants and needs. She further indicated that if she does not want to participate in an activity, she would throw items across the table or the room.

Review of the QIDP quarterly notes dated from November 2010 through August 6, 2011, revealed that Resident #1 required 40% physical assistance to complete the signs. The notes further revealed that the resident should continue to receive training on the manual sign language IPP. The QIDP confirmed that the resident does not use manual signs and she would speak to the

Client #1 was reassessed by the QIDP on 9-21-11
Client #1 does not communicate with sign language.
The goal has been revised and the criteria was changed to physical assistance.
Staff has been trained to physically assist client #1 in the implementation of the table top activities.
Refer to attachment #3
The Speech and Language Pathologist will assess Client #1 on 9-30-11
In the future, the QIDP will ensure that client #1's goal and objective coincide with her cognitive and adaptive abilities.

Client #1 was reassessed by the QIDP on 9-21-11
Client #1 does not communicate with sign language.
The goal has been revised and the criteria was changed to physical assistance.
Staff has been trained to physically assist client #1 in the implementation of the table top activities.
Refer to attachment #3
The Speech and Language Pathologist will assess Client #1 on 9-30-11
In the future, the QIDP will ensure that client #1's goal and objective coincide with her cognitive and adaptive abilities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 437	Continued From page 14 staff that worked on August 31, 2011, and documented on Resident #1's sign language IPP.	I 437		